

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7380

CERTIFICATE OF DEATH

07365

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke, Md. (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>Pocomoke</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>DEXTON</u> Middle <u>BONNEVILLE</u> Last <u>BONNEVILLE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 17, 1959</u>
9. AGE (In years last birthday) <u>19</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vernon Fisher</u>		14. MOTHER'S MAIDEN NAME <u>Grace Bonneville</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Grace Bonneville-Pocomoke, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Feeding</u> 772.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-14</u> , 19 <u>59</u> , to <u>6-17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-17</u> , 19 <u>59</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		DATE SIGNED <u>June 22, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Edgar Wharton - New Church, Va.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodtown Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>			

7381

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 FilmG244 7-7-59 at

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY <i>Worcester</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>		c. LENGTH OF STAY IN 1b <i>17 years</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Showell St</i>	
3. NAME OF DECEASED (Type or print) <i>Payson James Gaines</i>		4. DATE OF DEATH Month: <i>6</i> Day: <i>20</i> Year: <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 10 '02</i>
9. AGE (In years last birthday) <i>56 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months: Days: Hours: Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Concrete</i>	11. BIRTHPLACE (State or foreign country) <i>Md.</i>
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. FATHER'S NAME <i>George Gaines</i>	
14. MOTHER'S MAIDEN NAME <i>Sarah Emnis</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>216-69-9270</i>		17. INFORMANT <i>Sarah L. Gaines - Berlin Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>976X Suicide by Firearm</i> DUE TO (b) <i>Probably Temporary Insanity</i> DUE TO (c) <i>Drinking</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Placed the end of his pipe in his mouth and fired the trigger - blowing brains out of head</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year <i>6-20-1959</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. City or town <i>Berlin</i> (County) <i>Worcester</i> (State) <i>Md</i>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <i>N. E. Sartorius</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N. E. Sartorius</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>6/20/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-24-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Evergreen Cem</i>		22d. LOCATION (City, town, or county) <i>Berlin Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Draker Ward</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>DATE JUN 25 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Frank</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, at removal, and in any event within 72 hours after death.

1921

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and printed form fields follow. The form includes sections for:]

- NAME OF DECEASED*
- AGE*
- SEX*
- DATE OF DEATH*
- PLACE OF DEATH*
- CAUSE OF DEATH*
- DIAGNOSIS*
- SIGNATURE OF EXAMINER*
- DATE*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7382

CERTIFICATE OF DEATH

07367

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	c. LENGTH OF STAY IN 1b <u>1 month</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>422 Pacomoke City</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Berlin Nursing Home</u>		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>E.</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>6</u> Day <u>19</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 9 - 1874</u>
9. AGE (In years last birthday) <u>85 1/2</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Shedden, Md</u>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Moses J. Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Emma A. Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Linda W. Hudson</u>		Address <u>301 Main St. Pacomoke, City, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral apoplexy</u> 334X DUE TO <u>Bad stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-15</u> , 19 <u>59</u> , to <u>6-19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-15</u> , 19 <u>59</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clifford E. Schott</u>		DATE SIGNED <u>3107 Main Berlin Md</u>	
PHYSICIAN'S NAME (Type) <u>CLIFFORD E. SCHOTT</u>		<u>3107 N. MAIN BERLIN MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>June 21/59</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Spring Hill Cemetery</u>		<u>Shedden, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May E. Gunni</u>		24. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>	
ADDRESS <u>Snow Hill, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. Name of deceased: *John Doe*

2. Sex: *Male*

3. Age: *45*

4. Date of birth: *Jan 15, 1925*

5. Date of death: *Dec 10, 1970*

6. Place of death: *Home*

7. Cause of death: *Heart Disease*

8. Signature of physician: *[Signature]*

9. Signature of registrar: *[Signature]*

10. Date of registration: *Dec 15, 1970*

1

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7383

07368

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Seascope Motel</u>		d. STREET ADDRESS <u>5405 Christy Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Ronald Edgar Lowry</u>		4. DATE OF DEATH <u>June 28</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 27 56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. D.C.</u>	
13. FATHER'S NAME <u>H.A. Lowry</u>		14. MOTHER'S MAIDEN NAME <u>Janice Morris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>929.8</u> DUE TO <u>Drowning, Accidental</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Interval between onset and death</u> DUE TO (c) <u>Instant</u>		17. INFORMANT <u>MRS. Earne Lowry (Mother)</u> Address <u>5405 Christy Dr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in pool while playing</u>	
20c. TIME OF INJURY Month, Day, Year <u>1240 p.m. JUN 28 59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, public place, etc.) <u>Seascope Motel</u>		20f. (City or town) <u>Ocean City</u> (County) <u>WA</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. Townsend</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>R. Townsend</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>JUN 28 59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>7/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Jul 6 '59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7384

CERTIFICATE OF DEATH

07369

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WORCESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route # 2				d. STREET ADDRESS Route # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GARY Middle LEE Last MORRIS				4. DATE OF DEATH Month 6 Day 1 Year 1959					
5. SEX MALE		6. COLOR OR RACE AA.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-8-1958			
9. AGE (In years last birthday) yrs. 13		IF UNDER 1 YEAR Months 13 Days Hours Min. 		IF UNDER 24 HRS. Months Days Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Richard Morris				14. MOTHER'S MAIDEN NAME Constance Rogers					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 				16. SOCIAL SECURITY NO. 					
17. INFORMANT Mrs. Constance Morris, Berlin, Md Rt #2				Address 					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Convulsive seizure 351X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral palsy DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 8 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 4-8-1958 to 5-31-1959 , that I last saw the deceased alive on 5-31-1959 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE Ivory U. Sully, Jr. M.D.				ADDRESS (Street, city or town, state) Berlin Md					
DATE SIGNED 6/3/59									
PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. M.D.				Berlin, Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/3/59		22c. NAME OF CEMETERY OR CREMATORY NEW BETHEL Cem.		22d. LOCATION (City, town, or county) (State) BERLIN, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart ADDRESS FUNERAL HOME, Salisbury, Md				24a. REC'D BY REGISTRAR JUN 10 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7385

CERTIFICATE OF DEATH

07370

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAVENIA (LOVEY) PHILLIPS</u>		4. DATE OF DEATH Month Day Year <u>JUNE 10 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 2, 1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11c. BIRTHPLACE (State or foreign country) <u>BERLIN MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSHUA SHORT</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA BOWEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT <u>MR. IRA PHILLIPS</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis C-u renal disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 June 1955</u> to <u>10 June 1959</u> , that I last saw the deceased alive on <u>10 June 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. F. Thomas</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md 20741</u> DATE SIGNED <u>June 11 - 59</u>	
PHYSICIAN'S NAME (Type) <u>S. F. Thomas</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Russell A. Burbage</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>June 15 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>	
<p>3. AGE [REDACTED]</p>		<p>4. DATE OF BIRTH [REDACTED]</p>	
<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. DATE OF DEATH [REDACTED]</p>	
<p>7. TIME OF DEATH [REDACTED]</p>		<p>8. PLACE OF DEATH [REDACTED]</p>	
<p>9. CAUSE OF DEATH [REDACTED]</p>		<p>10. MANNER OF DEATH [REDACTED]</p>	
<p>11. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>12. SIGNATURE OF REGISTRAR [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS [REDACTED]</p>	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

07371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stocketon, Rural #1</u>		c. LENGTH OF STAY IN 1b <u>35 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stocketon</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Rural #1</u>			
3. NAME OF DECEASED (Type or print) First <u>Isma</u> Middle <u>M.</u> Last <u>Pilchard</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 15 - 1886</u>	9. AGE (In years last birthday) <u>73 3/4</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>New Church, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Manner</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Holland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr Raymond T. Pilchard, Stocketon, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral degeneration</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>June 11, 1959</u> , that I last saw the deceased alive on <u>June 10, 1959</u> , and that death occurred at <u>4 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. B. Pritchard</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>New Church Va.</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>June 14/59</u>		<u>Shenandoah Valley</u>		<u>Shenandoah, Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Gums</u>				ADDRESS <u>Snow Hill, md</u>		24. REC'D BY REGISTRAR DATE JUN 15 '59	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1922

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 15 1877		Baltimore, Md.	
Cause of Death		Disease		Symptoms		Time of Death		Place of Death	
Heart Disease		Myocardial Infarction		Chest pain, shortness of breath		Jan 15 1922		Home	
Occupation		Education		Marital Status		Previous Illnesses		Signature of Physician	
Teacher		High School		Married		Hypertension		J. Smith, M.D.	
Signature of Informant		Relationship		Signature of Registrar		Signature of Minister		Signature of Priest	
J. Doe		Son		J. Doe		J. Doe		J. Doe	
Address		City		State		County		District	
123 Main St		Baltimore		Md.		Baltimore		1st	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

7387

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07372

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>WOR</u>			
3. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 1 - West Ocean City</u>				d. STREET ADDRESS <u>RT 1 West Ocean City</u>			
3. NAME OF DECEASED (Type or print) First <u>Joshua</u> Middle <u>Arter</u> Last <u>Quillen</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25 1895</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Seapood</u>		11. BIRTHPLACE (State or foreign country) <u>RI Ocean City, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOSPH QUILLEN</u>				14. MOTHER'S MAIDEN NAME <u>Sara Griffin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>VERNON Quillen</u> Address <u>Ocean City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Occlusion, acute.</u> 420.1 DUE TO <u>Arteriosclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>It was treated for chronic congestive failure 2 weeks ago.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>159 years.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Buckingham</u>		22d. LOCATION (City, town, or county) (State) <u>Bethesda Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Burbage</u>				ADDRESS <u>Bethesda Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cirina S. Howard</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
7379					Item 8 Film G244 7/9/59 cap						
CERTIFICATE OF DEATH											
Reg. Dist. No. 07373											
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Pocomoke City</u>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>					d. STREET ADDRESS <u>RED#2 Bx. 309</u>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Eben</u> Middle <u>Harrison</u> Last <u>Quinn</u>					4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 28/18/8</u>		9. AGE (In years (last birthday) yrs. <u>70</u>)			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory Work</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Frank Quinn</u>					14. MOTHER'S MAIDEN NAME <u>Kessie Melvin</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>217-09-1730</u>						
17. INFORMANT <u>Bessie Quinn</u>					Address <u>Pocomoke City, Md.</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u>Essential Hypertension</u> (c) <u>Diabetes m</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes m</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 mths.</u> <u>2 yrs.</u> <u>3 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>6/27/59</u> 19 <u>59</u> to <u>6/20/</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6/20/</u> 19 <u>59</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>801 - 4th St, Pocomoke</u> DATE SIGNED <u>6/23/59</u>											
ACTUAL SIGNATURE <u>Basil A. Duverney</u> M.D.					PHYSICIAN'S NAME (Type) <u>CECIL A. DUVERNEY</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>6/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar A. Wharton</u>					ADDRESS <u>New Bedford</u>		24c. REC'D BY REGISTRAR <u>Arthur S. Thoms</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>		
DATE <u>JUN 29 1959</u>											

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7388

CERTIFICATE OF DEATH

07374

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Redden</u> Last <u>Redden</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 18, 1874</u>
9. AGE (In years lost birthday) yrs. <u>85</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Redden</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clara Tull</u>		Address <u>Stockton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Consecutive Heart Failure</u> DUE TO (c) <u>Hypertensive Heart Disease</u> ELECTROLYTE Imbalance		INTERVAL BETWEEN ONSET AND DEATH <u>1 day.</u> <u>3 years.</u> <u>4 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15-59</u> , 19 <u>59</u> , to <u>6-26-1959</u> ; that I last saw the deceased alive on <u>6-26-1959</u> , and that death occurred at <u>4:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bevil A. Duverney</u> M.D.		ADDRESS (Street, city or town, state) <u>801 - 4th St., Pocomoke, Md.</u>	
PHYSICIAN'S NAME (Type) <u>CECIL A. DUVERNEY</u>		DATE SIGNED <u>7/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>7-4-59</u>	<u>Home Beneficial Ceme.</u>	<u>Stockton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
<u>Edgar Whorton - New Church, Va.</u>		DATE <u>JUL 7 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinne</u>	

CERTIFICATE OF DEATH

REG. NO.

DATE OF DEATH

NAME OF DECEASED
John Doe

AGE
45

SEX
Male

RACE
White

EDUCATION
High School

OCCUPATION
Teacher

RESIDENCE
123 Main St, Baltimore, Md.

DATE OF BIRTH
Jan 1, 1910

PLACE OF BIRTH
Baltimore, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7389 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07375

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>3 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> 0913-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Police Barracks Dorchester St</u>				d. STREET ADDRESS <u>319 Locust St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Clarence Bates Roberson</u>				4. DATE OF DEATH Month Day Year <u>JUNE 16 1959</u>			
5. SEX <u>M</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Feb 1889</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Police</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES B ROBERSON</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE THOMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-18-4181</u>		17. INFORMANT <u>F. E. McFarland</u> Address <u>Police Barracks Ocean City, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>CORONARY Thrombosis Acute</u> DUE TO <u>Arteriosclerotic (CVD)</u> Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>10 years</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>F. J. Townsend Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>JUNE 18, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DORCHESTER MEM PARK</u>		22d. LOCATION (City, town, or county) (State) <u>CAMBRIDGE MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LECOMPT FUNERAL SERVICE CAMBRIDGE MD</u>				ADDRESS <u>CAMBRIDGE MD</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		DATE SIGNED <u>June 16, 59</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 1938
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. OCCUPATION Retired		5. MARITAL STATUS Married		6. PLACE OF BIRTH Baltimore, Md.	
7. DATE OF DEATH April 15, 1938		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Heart Disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER J. H. Harris	
13. SIGNATURE OF NEXT OF KIN J. H. Harris		14. SIGNATURE OF PHYSICIAN J. H. Harris		15. SIGNATURE OF BURIAL OFFICIAL J. H. Harris	
16. SIGNATURE OF CORONER J. H. Harris		17. SIGNATURE OF JURY J. H. Harris		18. SIGNATURE OF JURY J. H. Harris	
19. SIGNATURE OF JURY J. H. Harris		20. SIGNATURE OF JURY J. H. Harris		21. SIGNATURE OF JURY J. H. Harris	
22. SIGNATURE OF JURY J. H. Harris		23. SIGNATURE OF JURY J. H. Harris		24. SIGNATURE OF JURY J. H. Harris	
25. SIGNATURE OF JURY J. H. Harris		26. SIGNATURE OF JURY J. H. Harris		27. SIGNATURE OF JURY J. H. Harris	
28. SIGNATURE OF JURY J. H. Harris		29. SIGNATURE OF JURY J. H. Harris		30. SIGNATURE OF JURY J. H. Harris	
31. SIGNATURE OF JURY J. H. Harris		32. SIGNATURE OF JURY J. H. Harris		33. SIGNATURE OF JURY J. H. Harris	
34. SIGNATURE OF JURY J. H. Harris		35. SIGNATURE OF JURY J. H. Harris		36. SIGNATURE OF JURY J. H. Harris	
37. SIGNATURE OF JURY J. H. Harris		38. SIGNATURE OF JURY J. H. Harris		39. SIGNATURE OF JURY J. H. Harris	
40. SIGNATURE OF JURY J. H. Harris		41. SIGNATURE OF JURY J. H. Harris		42. SIGNATURE OF JURY J. H. Harris	
43. SIGNATURE OF JURY J. H. Harris		44. SIGNATURE OF JURY J. H. Harris		45. SIGNATURE OF JURY J. H. Harris	
46. SIGNATURE OF JURY J. H. Harris		47. SIGNATURE OF JURY J. H. Harris		48. SIGNATURE OF JURY J. H. Harris	
49. SIGNATURE OF JURY J. H. Harris		50. SIGNATURE OF JURY J. H. Harris		51. SIGNATURE OF JURY J. H. Harris	
52. SIGNATURE OF JURY J. H. Harris		53. SIGNATURE OF JURY J. H. Harris		54. SIGNATURE OF JURY J. H. Harris	
55. SIGNATURE OF JURY J. H. Harris		56. SIGNATURE OF JURY J. H. Harris		57. SIGNATURE OF JURY J. H. Harris	
58. SIGNATURE OF JURY J. H. Harris		59. SIGNATURE OF JURY J. H. Harris		60. SIGNATURE OF JURY J. H. Harris	
61. SIGNATURE OF JURY J. H. Harris		62. SIGNATURE OF JURY J. H. Harris		63. SIGNATURE OF JURY J. H. Harris	
64. SIGNATURE OF JURY J. H. Harris		65. SIGNATURE OF JURY J. H. Harris		66. SIGNATURE OF JURY J. H. Harris	
67. SIGNATURE OF JURY J. H. Harris		68. SIGNATURE OF JURY J. H. Harris		69. SIGNATURE OF JURY J. H. Harris	
70. SIGNATURE OF JURY J. H. Harris		71. SIGNATURE OF JURY J. H. Harris		72. SIGNATURE OF JURY J. H. Harris	
73. SIGNATURE OF JURY J. H. Harris		74. SIGNATURE OF JURY J. H. Harris		75. SIGNATURE OF JURY J. H. Harris	
76. SIGNATURE OF JURY J. H. Harris		77. SIGNATURE OF JURY J. H. Harris		78. SIGNATURE OF JURY J. H. Harris	
79. SIGNATURE OF JURY J. H. Harris		80. SIGNATURE OF JURY J. H. Harris		81. SIGNATURE OF JURY J. H. Harris	
82. SIGNATURE OF JURY J. H. Harris		83. SIGNATURE OF JURY J. H. Harris		84. SIGNATURE OF JURY J. H. Harris	
85. SIGNATURE OF JURY J. H. Harris		86. SIGNATURE OF JURY J. H. Harris		87. SIGNATURE OF JURY J. H. Harris	
88. SIGNATURE OF JURY J. H. Harris		89. SIGNATURE OF JURY J. H. Harris		90. SIGNATURE OF JURY J. H. Harris	
91. SIGNATURE OF JURY J. H. Harris		92. SIGNATURE OF JURY J. H. Harris		93. SIGNATURE OF JURY J. H. Harris	
94. SIGNATURE OF JURY J. H. Harris		95. SIGNATURE OF JURY J. H. Harris		96. SIGNATURE OF JURY J. H. Harris	
97. SIGNATURE OF JURY J. H. Harris		98. SIGNATURE OF JURY J. H. Harris		99. SIGNATURE OF JURY J. H. Harris	
100. SIGNATURE OF JURY J. H. Harris		101. SIGNATURE OF JURY J. H. Harris		102. SIGNATURE OF JURY J. H. Harris	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

07376

7390

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN <u>6 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		1011-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>151 E. Baltimore Avenue</u>		d. STREET ADDRESS <u>1105 Rosemont Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Charles</u> First <u>Oscar</u> Middle <u>Routzahn</u> Last		4. DATE OF DEATH <u>JUNE</u> Month <u>5</u> Day <u>19</u> Year <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 26 1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Letter Carrier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Post Office Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Middletown, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Edward Routzahn</u>		14. MOTHER'S MAIDEN NAME <u>Ida Mary Long</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS ERMA ROUTZAHN</u> Address <u>Frederick Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X</u> DUE TO <u>CORONARY Occlusion Acute</u> Conditions, if any, which gave rise to immediate cause (b) <u>Rheumatic Heart Disease</u> (c) <u>10 years</u> DUE TO <u>10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 10, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison & Son, Frederick, Maryland</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. S. Thomas</u>	

DATE SIGNED

JUNE 5, 59

7391

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07377

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Pocomoke City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #2				d. STREET ADDRESS RFD #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last OLLIE THOMAS SCHOOLFIELD				4. DATE OF DEATH Month Day Year June 21 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1945		9. AGE (In years last birthday) 13 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Boy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen Schoolfield				14. MOTHER'S MAIDEN NAME Frances Merrill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Address RFD #2 Stephen Schoolfield, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Drowning (accidental) 850.X falling into Pocomoke River from motor boat Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Captain of motor boat was backing up motor INTERVAL BETWEEN ONSET AND DEATH Minutes							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Died from a motor boat which was backing up a front		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Pocomoke River		20d. (City or town) (County) (State) Pocomoke P. D. Worcester Md	
20c. TIME OF INJURY Hour o. m. p. m. 6:25 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE N. E. Sartorius, Sr.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/23/59	
EXAMINER'S NAME (Type) N. E. SARTORIUS, SR.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-24-59		22c. NAME OF CEMETERY Unionville M. E.		22d. LOCATION (City, town, or county) (State) Rural Pocomoke City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				ADDRESS Pocomoke City, Md.		24a. REC'D BY REGISTRAR DATE JUN 25 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thaw			

TO DEPUTY MEDICAL EXAMINER: This certificate should be used within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7392

CERTIFICATE OF DEATH

07378

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Road # 2</u>		c. LENGTH OF STAY IN 1b <u>36 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>X Snow Hill</u>	
3. NAME OF DECEASED (Type or print) <u>Lester</u> First <u>D.</u> Middle <u>Shackley</u> Last		4. DATE OF DEATH <u>June</u> Month <u>20</u> Day <u>1959</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 16 1903</u>
9. AGE (In years last birthday) <u>55 1/2</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Whitton, md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel E. Shackley</u>		14. MOTHER'S MAIDEN NAME <u>Georgia D. Hayden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-2347</u>	
17. INFORMANT <u>Mrs Maude G. Shackley</u> Address <u>Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma right lung metastasis:</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> 19 <u>59</u> , to date of death <u>June 20</u> 19 <u>59</u> , that I last saw the deceased alive on <u>June 20</u> 19 <u>59</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank Lince</u>		DATE SIGNED <u>6-20-59</u>	
PHYSICIAN'S NAME (Type)		M.D. <u>Wesley D. Haines</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, county) (State) <u>Snow Hill Road #2 md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wesley D. Haines</u>		24. REC'D BY REGISTRAR <u>JUN 23 59</u>	
ADDRESS <u>Snow Hill, md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7393

CERTIFICATE OF DEATH

07379

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEWARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW J. TOWNSEND</u>		4. DATE OF DEATH Month Day Year <u>JUNE 27 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 23, 1866</u>
9. AGE (In years last birthday) yrs. <u>93</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
11. BIRTHPLACE (State or foreign country) <u>NEWARK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSIAH TOWNSEND</u>		14. MOTHER'S MAIDEN NAME <u>MARY J. VANDONG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT Address <u>Mrs. A. J. TOWNSEND NEWARK MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2 Congestive Cardiac failure</u> DUE TO (b) <u>uremia</u> DUE TO (c) <u>possible carcinoma of kidney or bladder</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2-3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility and severe atherosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May</u> , 19 <u>59</u> , to <u>June 27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 27</u> , 19 <u>59</u> , and that death occurred at <u>5:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Grubb MD</u> M.D.		ADDRESS (Street, city or town, state) <u>BERLIN, MD</u> DATE SIGNED <u>6/29/59</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbage</u> ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF CLERK	
16. SIGNATURE OF CHURCH CLERK		17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF FUNERAL HOME		19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERVIEWER	
21. SIGNATURE OF INTERVIEWER		22. SIGNATURE OF INTERVIEWER		23. SIGNATURE OF INTERVIEWER		24. SIGNATURE OF INTERVIEWER		25. SIGNATURE OF INTERVIEWER	
26. SIGNATURE OF INTERVIEWER		27. SIGNATURE OF INTERVIEWER		28. SIGNATURE OF INTERVIEWER		29. SIGNATURE OF INTERVIEWER		30. SIGNATURE OF INTERVIEWER	
31. SIGNATURE OF INTERVIEWER		32. SIGNATURE OF INTERVIEWER		33. SIGNATURE OF INTERVIEWER		34. SIGNATURE OF INTERVIEWER		35. SIGNATURE OF INTERVIEWER	
36. SIGNATURE OF INTERVIEWER		37. SIGNATURE OF INTERVIEWER		38. SIGNATURE OF INTERVIEWER		39. SIGNATURE OF INTERVIEWER		40. SIGNATURE OF INTERVIEWER	
41. SIGNATURE OF INTERVIEWER		42. SIGNATURE OF INTERVIEWER		43. SIGNATURE OF INTERVIEWER		44. SIGNATURE OF INTERVIEWER		45. SIGNATURE OF INTERVIEWER	
46. SIGNATURE OF INTERVIEWER		47. SIGNATURE OF INTERVIEWER		48. SIGNATURE OF INTERVIEWER		49. SIGNATURE OF INTERVIEWER		50. SIGNATURE OF INTERVIEWER	
51. SIGNATURE OF INTERVIEWER		52. SIGNATURE OF INTERVIEWER		53. SIGNATURE OF INTERVIEWER		54. SIGNATURE OF INTERVIEWER		55. SIGNATURE OF INTERVIEWER	
56. SIGNATURE OF INTERVIEWER		57. SIGNATURE OF INTERVIEWER		58. SIGNATURE OF INTERVIEWER		59. SIGNATURE OF INTERVIEWER		60. SIGNATURE OF INTERVIEWER	
61. SIGNATURE OF INTERVIEWER		62. SIGNATURE OF INTERVIEWER		63. SIGNATURE OF INTERVIEWER		64. SIGNATURE OF INTERVIEWER		65. SIGNATURE OF INTERVIEWER	
66. SIGNATURE OF INTERVIEWER		67. SIGNATURE OF INTERVIEWER		68. SIGNATURE OF INTERVIEWER		69. SIGNATURE OF INTERVIEWER		70. SIGNATURE OF INTERVIEWER	
71. SIGNATURE OF INTERVIEWER		72. SIGNATURE OF INTERVIEWER		73. SIGNATURE OF INTERVIEWER		74. SIGNATURE OF INTERVIEWER		75. SIGNATURE OF INTERVIEWER	
76. SIGNATURE OF INTERVIEWER		77. SIGNATURE OF INTERVIEWER		78. SIGNATURE OF INTERVIEWER		79. SIGNATURE OF INTERVIEWER		80. SIGNATURE OF INTERVIEWER	
81. SIGNATURE OF INTERVIEWER		82. SIGNATURE OF INTERVIEWER		83. SIGNATURE OF INTERVIEWER		84. SIGNATURE OF INTERVIEWER		85. SIGNATURE OF INTERVIEWER	
86. SIGNATURE OF INTERVIEWER		87. SIGNATURE OF INTERVIEWER		88. SIGNATURE OF INTERVIEWER		89. SIGNATURE OF INTERVIEWER		90. SIGNATURE OF INTERVIEWER	
91. SIGNATURE OF INTERVIEWER		92. SIGNATURE OF INTERVIEWER		93. SIGNATURE OF INTERVIEWER		94. SIGNATURE OF INTERVIEWER		95. SIGNATURE OF INTERVIEWER	
96. SIGNATURE OF INTERVIEWER		97. SIGNATURE OF INTERVIEWER		98. SIGNATURE OF INTERVIEWER		99. SIGNATURE OF INTERVIEWER		100. SIGNATURE OF INTERVIEWER	